TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-16-2487-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is also my understanding that a preauthorization is only required on items that are over $500 per line item in which these are not over that amount."

Amount in Dispute: $55.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A 30-day rental for the TENS unit was certified as medically necessary on 9/17/2015 by the URA. No further pre-authorization requests were made for the TENS unit. Thus, it's our position that the TENS supplies for the unit are not medically reasonable and necessary since continued used of the TENS unit was not pre-authorized."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2015	A4595, A4630	$55.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets our general guidelines for medical dispute resolution.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 293 – This procedure requires prior authorization and none was identified.

- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 960 – Services not medically appropriate or necessary.
- 96 – Non-covered charges(s).

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
2. What is the dispute process for resolving medical necessity denials?
3. What is the dispute sequence?
4. What are the filing requirements after the resolution of a medical necessity denial?
5. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for a claim with date of service December 21, 2015 for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code(s) "960 – Services not medically appropriate or necessary."
2. **Resolution of a Medical Necessity Dispute.** The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***
3. **Notice of Dispute Sequence.** 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.
4. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.
5. 28 Texas Administrative Code §133.307(f) (3) states that a dismissal is not a final decision by the division. Universal DME, LLC has the right to submit a new medical fee dispute after the medical necessity issue is resolved. Universal DME, LLC is responsible for filing for medical fee dispute not later than 60 days after the date the requestor receives the final Division decision. The 60-day filing requirement described in 28 Texas Administrative Code §133.307(c)(1)(B)(i) replaces the one-year filing deadline in those cases where a final decision regarding medical necessity is made. The division finds that due to the unresolved medical necessity issues, the medical fee dispute request for date of service December 21, 2015 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.